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VIEWPOINT

Universal Masking in the United States

The Role of Mandates, Health Education, and the CDC

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Supplemental
content

The Centers for Disease Control and Prevention (CDC) recommends cloth face coverings in public settings to prevent spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19). Face coverings decrease the amount of infectious virus exhaled into the environment, reducing the risk an exposed person will become infected.¹ Although many states and localities have ordered mask use, considerable variability and inconsistencies exist. Would a national mandate be an effective COVID-19 prevention strategy, and would it be lawful? Given the patchwork of state pandemic responses, should the CDC have enhanced funding and powers to forge a nationally coordinated response to COVID-19 and to future health emergencies?

Evidence Supporting Population-Based Face Coverings

In early February 2020, the CDC recommended mask use for anyone exhibiting COVID-19–like symptoms to reduce the spread of respiratory droplets.² On April 3, 2020, following recognition that viral load is high just before and early in the course of COVID-19 disease, the agency expanded its recommendation, urging mask use by the general public. Face masks significantly

individuals with medical conditions or disabilities that render it difficult to wear face coverings.

States undoubtedly have the power to require mask use. Yet because face coverings have become associated with political or other symbolic meaning, some have challenged mandates as violating the First Amendment. A federal district court in Maryland rejected this argument, holding that wearing a face covering simply conveys the idea that masks protect the public, nothing more. The US Supreme Court recently upheld COVID-19 restrictions on religious worship as a valid public health measure,⁶ and similar reasoning could apply to masks. The Occupational Safety and Health Administration also permits employers to require face coverings to abate the spread of SARS-CoV-2. Similarly, businesses can require customers to use masks as a condition of service.

Despite the prevalence of lawful orders, masks are not required in many parts of the United States, leading to a patchwork of protection. Georgia's governor, for example, issued an executive order preempting local mask mandates.⁷ In states without mask requirements, there is considerable local variation in mask use. With intrastate and interstate travel, the lack of uniformity and consistency has proven to be an obstacle to progress in the COVID-19 crisis.

Although a federal mask mandate may appear to be an attractive policy, it could encounter legal challenges, be difficult to enforce, and further politicize wearing of masks. It is not clear whether the CDC has the authority to mandate face coverings nationwide. The Public Health Service Act grants the CDC powers to detain and medically examine potentially infected persons arriving into the United States and traveling between states, but this authority is unlikely to extend to regulatory actions such as requiring masks. Congress probably could enact a national mandate under the commerce power but has not done so. A federal mandate, moreover, might provoke political opposition to face coverings rooted in state sovereignty.

A better way to gain more national uniformity is by inducing states to enact mask laws. This respects states as key decision makers in public health and is more consistent with state autonomy. It is also easier to gain compliance with state and local directives rather than using federal officers to monitor and enforce a national mandate.

A well-crafted use of federal spending powers would likely be constitutional. Congress could attach conditions on the receipt of federal funds, inducing states to adopt a mandate. Intoxicated driver laws offer an analogy. The Supreme Court upheld a federal law

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reduce detection of influenza virus RNA in respiratory droplets and coronavirus RNA in aerosols.³ In a large health care system, a policy of universal masking was associated with steady declines in COVID-19–positive tests.⁴ An evaluation of state policies showed greater declines in daily COVID-19 cases after issuing mask mandates compared with states that did not have mandates.⁵ Face coverings offer source control to prevent exposing others and may offer protection to users. The ethical justification for face coverings is their utility in preventing transmission of serious disease to community members.

Mask Mandates: Lawfulness, Compliance, Utility

As of July 27, 2020, statewide orders mandating face coverings in response to COVID-19 had been issued in 31 states and the District of Columbia. Mandates vary, including directives to the general public, specific types of businesses, and to employers, employees, or both (see Table in Supplement 1). Most states grant exemptions for

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conditioning 5% of highway funds on states adopting a 21-year-old drinking age.⁸ The court probably would similarly uphold a federal law designating a reasonable portion of COVID-19 emergency funding on the condition that states issue mask directives. It is possible, however, that some states would reject a mask mandate, thus doubly jeopardizing their residents' health—no funding and no mask mandate.

Face Coverings as Part of a Comprehensive COVID-19 Prevention Strategy

Law can be a powerful tool for encouraging health behaviors. Laws requiring seatbelts offer a good analogy. Despite early opposition, the public came to regard passenger restraints as minimally invasive and vital safety features. Mask orders similarly could gain public acceptance because they are designed to protect mask wearers and the wider community. Mask laws cannot be successful alone but should be combined with a well-funded and well-designed health education campaign. Comprehensive and consistent public messaging is essential: "when we all mask up, we are all safer." A well-crafted message addressing the common good could significantly increase mask use, changing social norms to achieve near universal compliance.

CDC Funding and Powers in Health Emergencies: Time for a Reassessment?

When the history of COVID-19 is written, the role of the CDC will come under particular scrutiny. The most important conversation now is how to proactively prepare for the next pandemic. What funding, powers, and independence did the agency lack that could have made a difference?

Historically, states and localities have assured the public's health, with the CDC providing funding, technical guidance, and coordination. National coordination is achieved as states adopt evidence-based recommendations from the CDC. This model, however, breaks down if the federal government does not consistently support the CDC and the science undergirding its guidelines.

The state-by-state approach, moreover, is ill suited to health emergencies, which spill over to adjoining states, even the entire country. National leadership and a national plan are required. As mask use illustrates, state policies rapidly and forcefully affect US regions and the United States overall. States that reopened too soon experienced surges in COVID-19 cases, which spread across state borders. The CDC principally derives its powers from the Public Health Service Act, enacted in 1944. Congress could not have anticipated the complex national response pandemics like COVID-19 demand, including testing, contact tracing, stay-at-home orders, and a national health information system. In planning for the next pandemic, Congress should consider affording the CDC with flexible powers to ensure a uniform, well-coordinated response to prevent interstate spread of novel diseases.

COVID-19 teaches other lessons, including the importance of ample health funding, greater autonomy of public health agencies, and preserving the integrity of science. As the Institute of Medicine recommended for the Food and Drug Administration commissioner, the CDC director could be appointed to a 6-year cross-administration term, mirroring the heads of the National Science Foundation and Social Security Administration.⁹ Yet even a 6-year term may not ensure CDC independence in a highly partisan political environment. An unreceptive White House or Congress can easily subvert science-based policy. The CDC also needs greater budgetary independence. Like the Social Security Administration, the CDC should submit its budget requests directly to Congress without the President being able to alter that budget before submission.¹⁰ Congress should also create an emergency fund, enabling a surge response without prior congressional approval.

The CDC's mission of safeguarding US health security through the application of science is of the highest importance to US residents. The COVID-19 pandemic offers a rare opportunity to strengthen that agency, affording the CDC the authority, funding, and independence necessary for a healthy and safe population.

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